STATE OF LOUISIANA
LEGISLATIVE AUDITOR

Department of Health and Hospitals -
Medical Assistance Program -
Dental Services
State of Louisiana
Baton Rouge, Louisiana

August 9, 2000

Financial and Compliance Audit Division

Daniel G. Kyle, Ph.D., CPA, CFE
Legislative Auditor

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DEPARTMENT OF HEALTH AND HOSPITALS - MEDICAL ASSISTANCE PROGRAM - DENTAL SERVICES STATE OF LOUISIANA

Baton Rouge, Louisiana

Financial Related Audit and
Independent Auditor's Report
Dated July 5, 2000

August 9, 2000

DEPARTMENT OF HEALTH AND HOSPITALS -
MEDICAL ASSISTANCE PROGRAM -
DENTAL SERVICES
Baton Rouge, Louisiana

Financial Related Audit and
Independent Auditor's Report
Dated July 5, 2000

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The Department of Health and Hospitals (DHH) paid approximately $21.1 million to 800 active dental providers for dental services under the Medicaid Dental Program during calendar year 1998. DHH also had a $1.4 million contract with the Louisiana State University (LSU) School of Dentistry for the period July 1, 1996, to June 30, 1999, to provide the surveillance and utilization review function within the Medicaid Dental Program for dental services.

Our financial related audit found that:

- Of the ten dental providers reviewed, nine providers billed the Medicaid Dental Program for 830 services costing $39,827 that were not in accordance with the *Medicaid Dental Services Manual.*

- The LSU School of Dentistry is not performing an effective surveillance and utilization review function for the Medicaid Dental Program.

- The LSU School of Dentistry dental consultants did not always follow the established guidelines when pre-authorizing dental services for the Medicaid Dental Program.

- Certain dental providers may be billing the Medicaid Dental Program for unnecessary hospital services.

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July 5, 2000

Independent Auditor's Report

DEPARTMENT OF HEALTH AND HOSPITALS
STATE OF LOUISIANA
Baton Rouge, Louisiana

We have performed a financial related audit of the Department of Health and Hospitals (DHH or department) regarding dental services provided under the Medical Assistance Program. The purposes of our financial related audit were to determine if payments for dental services under the Medical Assistance Program (Medicaid, CFDA #93.778) during the period January 1, 1998, to December 31, 1998, were in accordance with federal and state guidelines and to review the adequacy of the surveillance and utilization review function performed by the Louisiana State University (LSU) School of Dentistry.

Our audit was performed in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States, applicable to a financial related audit. Our limited procedures consisted of (1) interviewing certain department and dental school personnel; (2) reviewing selected dental provider records and payments to those providers; (3) examining selected departmental and dental school records; (4) reviewing applicable federal and state laws and regulations for the Medical Assistance Program; (5) reviewing the contract between the department and the LSU School of Dentistry; and (6) making inquiries to the extent we considered necessary to achieve our purpose.

These limited procedures are substantially less in scope than an audit of financial statements in accordance with government auditing standards, the purposes of which are to provide assurances on the entity's presented financial statements, assess the entity's internal control, and assess the entity's compliance with laws and regulations that could materially impact its financial statements. Had we performed such an audit, or had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

Based on the application of the procedures referred to previously, the accompanying findings and recommendations represent those conditions that we feel warrant attention by the appropriate parties. Management's responses to the findings and recommendations presented in this report are included in Appendix A.

DEPARTMENT OF HEALTH AND HOSPITALS
STATE OF LOUISIANA
Financial Related Audit, Dated July 5, 2000

This report is intended solely for the information and use of the Department of Health and Hospitals and its management and is not intended to be, and should not be, used by anyone other than these specific parties. Under Louisiana Revised Statute 24:513, this report is distributed by the Legislative Auditor as a public document.

Respectfully submitted,

Daniel G. Kyle, CPA, CFE
Legislative Auditor

JES:EFS:DSP:dl

[DHH-SP]

Introduction

CREATION AND DUTIES

The Department of Health and Hospitals (DHH or the department) was created in accordance with Title 36, Chapter 6 of the Louisiana Revised Statutes of 1950, as a part of the executive branch of government. DHH is charged with providing health and medical services for the uninsured and medically indigent citizens of Louisiana. Services provided by DHH include, but are not limited to, services for the mentally ill, for persons with retardation and developmental disabilities, for alcohol and drug abusers, public health services, and services provided under the Medicaid Program.

The Medicaid Dental Program (Dental Program) was established under the department's Medicaid State Plan, which is approved by the Federal Health Care Financing Administration. The Dental Program guidelines are provided in the department's *Dental Services Manual.* This manual addresses individual programs within the dental program and other areas including eligibility, provider participation, and claim filing. According to the guidelines, reimbursement for dental services may be made when these services are provided to eligible Medicaid recipients by qualified, enrolled providers.

The Code of Federal Regulations (42 CFR 456.3) states that the Medicaid agency must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments. To comply with this requirement, the department has a Program Integrity section to perform surveillance and utilization review on all Medicaid services except dental services. The department has contracted with the Louisiana State University (LSU) School of Dentistry to perform this function for dental services. The objectives of the contract for the period July 1, 1996, to June 30, 1999, were to:

1. Provide the department's surveillance and utilization review unit with the expertise necessary to assure the integrity of its Medicaid Dental Program.

2. For individuals with mental retardation residing in state developmental centers, implement and monitor dental preventative programs that support regulatory and quality improvement relating to Standards for Federal Title XIX ICF-MR's, Standards for Services by the Accreditation Council, State of Louisiana Abuse/Neglect Policies, State of Louisiana Peer Review Guidelines, and all other applicable regulations.

3. Review and prior authorize requests for dental services submitted by Medicaid dental providers.

The Dental Medicaid Unit within the LSU School of Dentistry has the responsibility for performing the surveillance and utilization review function. The department paid the LSU School of Dentistry approximately $1.25 million during this three-year contract period. In December 1999, the department approved a new contract for the period of July 1, 1999, to June 30, 2002, for approximately $1.5 million.

OBJECTIVES

The objectives of our financial related audit were to:

- Determine if payments for dental services under the Medicaid Dental Program were in accordance with federal and state guidelines.

- Review the adequacy of the surveillance and utilization review function performed by the LSU School of Dentistry.

METHODOLOGY

Our limited procedures consisted of the following:

1. Analyze the Medicaid Provider File and the Paid Claims History File for calendar year 1998 to identify "high risk" dental providers. The files provided information such as dental providers, the amounts paid to dental providers, types of service, claim identification numbers, recipient names and numbers, procedures performed, diagnosis, dates of service, dates of claims, dates paid, and amounts billed. Using Audit Command Language, we considered the provider's volume, location, and whether the provider was an individual or group practice. We also evaluated the number and dollar amount of claims and the number of recipients per provider. Based on this information, ten providers were chosen for review.

2. Select ten recipients (patients) from each of the ten providers and examine recipients' charts for the entire calendar year to ensure proper billing of dental services.

3. Review the contract between the department and the LSU School of Dentistry for the period July 1, 1996, to June 30, 1999.

4. Interview certain LSU School of Dentistry personnel and review the surveillance and utilization review cases opened by the Dental Medicaid Unit to obtain an understanding of the unit's operations.

5. Review applicable federal and state guidelines.

Findings and Recommendations

In conducting the procedures previously described, our financial related audit resulted in the following findings and observations.

IMPROPER CLAIMS BY DENTAL PROVIDERS

Providers of dental services billed the Medicaid Program for 830 services costing $39,827 during calendar year 1998 that were not in accordance with the *Medicaid Dental Services Manual*. A service is defined as any one of the procedure codes listed in the *Medicaid Dental Services Manual*, Appendix A. Our review of the dental claims of ten dental providers disclosed the following:

- Five providers were paid $32,231 for services performed by an associate rather than the billing dentist. This condition was found for 51 of 81 (63%) recipients examined, resulting in 768 of 1,289 services being billed improperly. In four cases, the associates were not enrolled in the Medicaid Program. The *Medicaid Dental Services Manual* states that to participate in Medicaid, providers must complete a Medicaid PE-50 enrollment form. In addition, the Dental Services Billing form requires the signature of the treating dentist. In each case, the treating physician was misrepresented on the claim form. The *Dental Services Manual* defines provider fraud as "materially misrepresenting dates and description of services rendered, the identity of the individual who rendered the services, or the recipient of the services." During 1998, these five providers were paid $1,641,909 for 68,606 dental services, an average of over $328,000 per provider.

  The department must know who performed the services or else it will have no way of verifying that only providers certified to participate in the program are providing dental services to Medicaid recipients. Unless the provider is certified to participate in the Medicaid program, the department does not know if the provider is qualified to perform the dental services.

- Five providers billed the Medicaid Program for $5,865 for services before dentures or other appliances were delivered to the recipient. This condition was found in 16 of the 18 (89%) recipients examined, resulting in 24 of 27 services being billed improperly. Chapters 4 and 5 of the *Medicaid Dental Services Manual* states that a claim for the payment of services should not be submitted before the service is provided. For example, the provider must place a denture in the patient's mouth before payment can be requested. During 1998, these five providers were paid $193,012 for 783 services relating to dentures or appliances.

- Two providers were paid $685 for 23 premedication services rendered to 18 recipients. Chapter 4 of the *Medicaid Dental Services Manual* states that premedication is not reimbursable. The providers were able to obtain reimbursement for all 23 services because the charges were billed using the procedure code for "Behavior Management," an allowable charge for the

Medicaid Program. During 1998, these two providers were paid $10,615 for 355 behavior management services.

- One provider was paid $210 for seven behavior management services provided to seven of the ten recipients examined. However, there was no documentation to support the need for the services. Chapter 4 of the *Medicaid Dental Services Manual* states that those patients below the age of six for whom a behavior management fee is requested must require special treatment that substantially adds to the time required to render treatment. Documentation of behavior management efforts is required. During 1998, this provider was paid $11,270 for 376 behavior management services.

- One provider was paid $836 for eight services that had not been performed. The Manual, Chapter 5, updated by the *1998 Louisiana Medicaid Provider Training Manual*, states that a recipient can only have one complete set of dentures in a seven-year period. The provider had made and delivered a complete set of dentures for two recipients. Since the two recipients were not eligible for dentures because of the seven-year limitation, the provider billed for other procedure codes in order to receive some reimbursement.

The department should review these claims and recoup any payments not made in accordance with the *Medicaid Dental Services Manual*. In addition, the department should review charges made by other dental providers for similar services to ensure that the Medicaid Program reimburses only allowable services. Also, the LSU School of Dentistry dental consultants need to develop new procedures as part of their surveillance and utilization review to detect the type of billing by providers described previously.

INEFFECTIVE SURVEILLANCE AND UTILIZATION REVIEW FUNCTION

The surveillance and utilization review function within the Medicaid Program for dental services is ineffective. The Code of Federal Regulations (42 CFR 456.3) states that the Medicaid agency must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments. The department has contracted with the LSU School of Dentistry to perform the surveillance and utilization review function for dental services that are provided to Medicaid recipients.

A review of the surveillance and utilization review efforts by the LSU School of Dentistry disclosed the following:

- During our review of dental claims, nine of the ten (90%) providers reviewed had improperly billed the Medicaid Program. These improper billings included numerous violations of the Medicaid Dental Services policies and potential fraud that would have been found if the LSU dental consultants had conducted routine site visits to examine Medicaid recipients' charts.

- The Dental Medicaid Unit (DMU) within the LSU School of Dentistry does not have the ability to analyze the total population of dental claims to identity potential fraud. The DMU relies on exception reports produced by the DHH Program Integrity section (the primary surveillance and utilization review unit

within the Department of Health and Hospitals). However, these reports are not an effective tool to identify potential misuse of Medicaid resources; past attempts to modify the reports have failed to produce more usable data.

- A review of the case files at the dental school revealed two cases in which the dental consultants were aware of improper billings to the Medicaid Program; however, no action was taken to recoup the improper payments or follow-up to ensure that the improper billing practices were stopped. The improper payments involved providers billing before delivery of appliances to Medicaid recipients and services being provided by associates as discussed in the finding titled "Improper Claims by Dental Providers."

The department should require the LSU School of Dentistry to revise its procedures to ensure that Medicaid dental services payments are subjected to an adequate surveillance and utilization review function. These revised procedures should include routine site visits, improved exception reports, and proper follow-up on problem areas found.

PRE-AUTHORIZATION PROCEDURES FOR CERTAIN SERVICES NOT FOLLOWED

The LSU School of Dentistry dental consultants did not always follow the established guidelines when pre-authorizing dental services for the Medicaid Program. A review of ten dental providers disclosed the following:

- Nine of ten patients of one provider had dental procedures that were pre-authorized by the LSU dental consultants although the required X-rays were not submitted with the request for authorization. The *Medicaid Dental Services Manual* states that X-rays that depict the condition of the entire mouth must accompany requests for authorization.

  The provider was reimbursed $5,634 for the nine patients that received services that required pre-authorization. The total paid to this single provider during calendar year 1998 was $458,713, of which approximately $223,004 required pre-authorization for services.

  The Manual also states that "the LSU School of Dentistry dental consultants will return all incorrect or incomplete claims forms to the provider for correction prior to considering approval of the requested service." There was no indication that the dental consultants had returned the claims to the providers with a request for the missing X-rays. Unless the X-rays are present, the dental consultants cannot make a meaningful determination as to whether there is a need for the services.

- Nine of 19 patients of two providers were given pre-authorization for hospital services without the required justification. These providers were paid $1,250 for these services.

> The *Medicaid Dental Services Manual* states that hospitalization solely for the convenience of the patient or the dentist is not allowed. Hospitalization must be justified by the physical condition of the patient, the age of the patient, or the severity of the procedures to be performed.

The LSU School of Dentistry dental consultants should follow the *Medicaid Dental Services Manual*, which requires that (1) the dental provider submit the required X-rays with a request for authorization of services and (2) requests for hospital services have the required justification.

Matters for Additional Consideration

During our financial related audit, we noted areas that may require additional consideration of management. These areas were not within the scope of our financial related audit, and no additional work was conducted. However, the department should review these issues and should seek to resolve or arbitrate the matters.

POTENTIAL OVERUSE OF HOSPITALIZATION SERVICES

Certain dental providers may be billing the Medicaid Program for unnecessary hospital services. The *Medicaid Dental Services Manual* states that hospitalization solely for the convenience of the patient or the dentist is not allowed. Hospitalization must be justified by the physical condition of the patient, the age of the patient, or the severity of the procedures to be performed.

A review of the eight providers performing dental services on children during calendar year 1998 disclosed that two providers did not perform any hospital services, three providers performed hospital services on less than 2% of their patients, while the remaining three providers performed hospital services on 10%, 11%, and 41% of their patients. During 1998, the Medicaid Program paid 63 dentists $342,679 for 2,746 hospital services. The three "high-use" providers we identified performed 637 hospital services, which is 23% of the total hospital services provided to Medicaid dental patients during 1998.

Payments to providers represent only a part of the cost of treating patients in a hospital setting. During 1998, the total average cost of treating a patient in a hospital setting, including the hospital fee, the anesthesiology fee, and the dentist's hospital fee, was approximately $575. Therefore, the 2,746 hospital services cost the Medicaid Program approximately $1.6 million.

The department should consider the possibility that certain dental providers are billing the Medicaid Program for unnecessary hospital services, while also increasing the cost to the Medicaid Program for patient hospitalization. The department should review and reconsider its procedures for authorizing the payment of hospitalization services and address the issue through the surveillance and utilization review function.

POTENTIAL CONFLICT OF INTEREST

The LSU School of Dentistry serves as the surveillance and utilization review function for all dental claims submitted by Medicaid dental providers but is also a Medicaid dental provider and has faculty members that are individual providers. This arrangement may cause a potential conflict of interest as it allows the School of Dentistry and certain faculty members to submit claims for approval or pre-authorization through its own review function.

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Appendix A

Management's Responses to the Findings and Recommendations and the Corrective Action Plans

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

July 14, 2000

M. J. "Mike" Foster, Jr.
GOVERNOR

LOUISIANA
Department of HEALTH and HOSPITALS

David W. Hood
SECRETARY

Dr. Daniel G. Kyle, CPA, CFE
Legislative Auditor
Office of Legislative Auditor
1600 North Third Street
Baton Rouge, LA 70802

Re: Medicaid Dental Services Program
Medicaid Dental Program Audit
Exit Conference Response

Dear Dr. Kyle:

This letter is in reference to your correspondence dated July 5, 2000 regarding the dental audit exit conference. Our response to the exit conference is attached as requested.

Included in these attachments are the corrective actions taken by the Department of Hospitals to date, applicable to each of the three reportable findings (Improper Claims By Dental Providers, Ineffective Surveillance and Utilization Review Function, and Pre-Authorization Procedures for Certain Services Not Followed).

During the exit conference, it was agreed that the fourth reportable finding, "Potential Overuse of Hospitalization Services", would be removed as a finding and would appear under the section entitled, "Matter for Additional Consideration". Our response to the section entitled, "Matter for Additional Consideration" is also attached.

Should you have any questions regarding this matter you may contact Terri Norwood by calling 225-342-9403.

Sincerely,

Ben Bearden
Director

BAB/BEG/TBN

Attachments

cc: Stan Mead
Bruce Gomez
Janis Souvestre
Dental Audit File

Improper Claims By Dental Providers

- Finding: Five providers were paid for services performed by an associate rather than a billing dentist. In each case the treating physician was misrepresented on the claim form.

  Summary: We concur in part to this finding. The Medicaid Dental Services Manual (Page 3-2) states that to participate in Medicaid, providers must complete a Medicaid PE-50 enrollment form, however, there is obvious confusion by some dentists as to who is considered the provider and who must enroll. A portion of the dental community operates in a business sense in that the owner of the dental clinic visualizes himself as the provider of the service and the dentists he employs as an employee acting on his behalf (similar to a nurse working for a physician). Therefore, these dentists feel that any services done by his employees are done on his behalf and therefore, the services can be billed to Medicaid under his Medicaid number.

  The instruction for claims completion is stated in the Medicaid Dental Services Manual on Page 7-9. It instructs the provider to enter the provider's signature, provider number (not license number), and the date. The Dental Services Manual does not state that it should be the attending dentist whose name appears in this location of the dental claim form. As stated in the previous summary, some dentists thought that they could bill under their Medicaid number when a service was provided by any employee working under him. The 1998 and 1999 Dental Services Provider Training Manuals instruct the provider to enter the attending provider's signature, attending provider number and the date. However, only those providers who attend the Provider Workshops receive the training manuals.

Corrective Action: A regulation will be promulgated in order to ensure that dental providers who provide services are enrolled. The regulation will state that the attending dentist must be indicated on the claim form and shall be enrolled in Medicaid even if they are only an employee of a dental provider. A Provider Update or Remittance Advice message will also be generated to provide this information.

The new Dental Services Manual, which is in production at this time, will incorporate clarification of provider enrollment requirements. The new policy will state that the dentist providing the dental service must be enrolled in the Medicaid Program in order to bill and receive payment from Medicaid and must be listed as the attending dentist on the claim form. The instructions for claims completion will be updated in the new Dental Services

Manual to instruct that the attending dentist's signature be entered on the dental claim form. We anticipate that this corrective action will be completed within 180 days.

Corrective Action To Date: A draft of guidelines for dentist enrollment in Medicaid is completed. Once circulated and approved, it will be promulgated as a regulation. The information will be included with the dental provider enrollment package, the new Dental Services Manual, and generated as a provider update and/or remittance advice message.

- Finding: Five providers billed Medicaid for dentures or other appliances prior to the delivery of the service.

Summary: We concur with this audit finding. The Medicaid Dental Services Manual (Page 4-5) and (Page 5-4) states that a claim for payment of services should not be submitted before the service is provided. Providers were found to bill when an impression was taken rather than when the actual service was finalized.

Corrective Action: Dental SURS will open a case on these 5 providers to ensure that the service was delivered. If it is discovered that the service was not delivered, the fee for that service will be recouped and appropriate sanctions will be applied. The Dental SURS Unit will review records to ensure that a claim for payment of services is not submitted before the service is provided.

A Provider Update and/or a Remittance Advice message will reiterate policy to remind providers that they should not bill Medicaid prior to the final delivery of the service. The new Medicaid Dental Services Manual will be clarified and will state that providers should not bill Medicaid prior to the final delivery of the service. We anticipate that this corrective action will be completed within 90 days.

Corrective Action To Date: Cases have been opened on each of the 5 providers identified in the dental audit and are being reviewed. Appropriate actions will be taken by the DMU based on the findings and the approval of DHH.

The DMU is reviewing cases in order to ensure that a claim for payment of services is not submitted before the service is provided. A letter for provider education and sanction is being drafted for use when a provider is in violation of policy. It will be implemented as soon as approved by DHH.

A remittance advice message was generated on May 23, 2000 and June 13, 2000 to remind providers of the policies and procedures mentioned above.

- Finding: Two providers were paid for premedication services. Providers are billing the behavior management code and the only documentation listed is premedication.

Summary: We concur with this finding. The Medicaid Dental Services Manual (Page 4-19) states that "premedication is not reimbursable." Although we do not reimburse for premedication, we do reimburse for behavior management. Premedication can be used in association with a behavior management problem and some providers may be providing behavior management services but using the word premedication to document the service. When providing behavior management services, providers need to provide specific documentation indicating the exact methods used which required special treatment which substantially added to the time required to render the treatment.

Corrective Action: Dental SURS will open a case on these two providers to review justification of behavior management and if no documentation is found indicating the method used to deliver behavior management, the fee for this services will be recouped and appropriate sanctions will be applied. Dental SURS will review records obtained to ensure documentation exists to specify behavior management methods used. If no documentation is found to indicate the method used to deliver behavior management, the fee for this service will be recouped.

A Provider Update and/or a Remittance Advice message will instruct the dental providers to further document the behavior management problem in the patient's record and on the Prior Authorization request and not document only as premedication. Also, the dental contractor will return any requests for prior authorization for behavior management services which are listed only as "premedication," with a request that language specifying the need for additional treatment time is included. We anticipate that this corrective action will be completed within 90 days.

Corrective Action To Date: Cases have been opened on the 2 providers identified in the audit and are being reviewed. Appropriate actions will be taken by the DMU based on the findings and DHH approval.

The DMU is reviewing other cases in order to ensure that justification of behavior management is documented. A letter for provider education and sanction is being drafted for use when a provider is in violation of policy. It will be implemented as soon as approved by DHH.

A remittance advice message was generated on May 23, 2000 and June 13, 2000 in order to remind providers of the policies and procedures mentioned above.

- Finding: One provider billed for Behavior Management and provided no documentation to support the need for the services.

Summary: We concur with this finding. The Medicaid Dental Services Manual (Page 4-19) states, "Those patients below the age of six for whom a behavior management fee is requested must require special treatment (papoose board, manual restraints, other behavior control methods) which substantially adds to the time required to render treatment. Documentation of management efforts is required."

Corrective Action: Dental SURS will review the dentist record to insure that justification of behavior management is in the record. If no documentation is found, the undocumented services will be recouped and appropriate sanctions will be applied. Dental SURS will include behavior management in the exception report.

A Provider Update and/or a Remittance Advice message will be generated to reiterate that documentation of the means used to provide behavior management must be provided in the patient's record and on the PA request indicating specifically what management efforts were required in order to receive reimbursement for behavior management. We anticipate that this corrective action will be completed within 90 days.

Corrective Action To Date: A case has been opened on the provider identified in the audit and is being reviewed. Appropriate actions will be taken by the DMU based on the findings and DHH approval.

The DMU is reviewing other cases in order to ensure that justification of behavior management is documented. A letter for provider education and sanction is being drafted for use when a provider is in violation of policy. It will be implemented as soon as approved by DHH.

A remittance advice was generated on May 23, 2000 and June 13, 2000 in order to remind providers of the policies and procedures mentioned above.

- Finding: Payment for services not performed. The provider made and delivered a complete set of dentures to two recipients who were not eligible for dentures due to the seven-year limitation and billed for other procedure codes in order to receive some reimbursement.

Summary: We concur with this finding. The Medicaid Dental Services Manual - Adult Dental Program (Page 5-7) states that "One complete denture and one reline per arch are allowed in a five-year period." However, on February 20, 1996, a regulation was promulgated by the Department to establish the period of waiting between Medicaid payment of dentures from five to seven years. A clarification to this rule was promulgated on March 20, 1999 to assure that partial dentures were included in this seven-year waiting period. The provider should not bill for other services in order to avoid these regulations.

Corrective Action: Dental SURS will review these two records to determine if the services were performed. If the services were not performed, the fees will be recouped and appropriate sanctions will be applied.

Dental SURS will review case records to ensure that payment was not received for services other than those performed. We anticipate that this corrective action will be completed within 90 days.

Corrective Actions To Date: The DMU has opened a case on this provider and it is being reviewed. Appropriate actions will be taken based on the findings and DHH approval.

The DMU is reviewing cases in order to ensure that the services in which the provider received payment were performed. A letter for provider education and sanction is being drafted for use when a provider is in violation of policy. It will be implemented as soon as approved by DHH.

Ineffective Surveillance and Utilization Review Function

- Finding: Improper billing which may have been discovered if the LSU dental consultants conducted routine site visits.

  Summary: We concur that if a state of the art program for detecting an aberrancy is instituted in the dental program, then the incidence of billing errors would be diminished due to the deterrent factor of a more thorough and up-to-date review process. The Bureau conducts onsite visits of aberrant providers when the medical records obtained from the provider indicate that a serious abuse of the programmatic rules is occurring. Routine site visits for the purpose of chart reviews are conducted but only on cases where an exception of a provider from his peer group occurs and when an in-house review of provider records indicates that a closer on-site review is appropriate. Cost effectiveness and efficiency of effort necessitate us from randomly visiting providers to review records. Field reviews of dental providers occur now. Current protocol for reviews eliminates the prior authorized procedures from further scrutiny.

  Corrective Action: Current protocol will be changed to require that prior authorized procedures be subjected to the same review as procedures not requiring review. We anticipate that this corrective action will be completed within 60 days.

  Corrective Action To Date: The Control File has been updated through PC SURS utility to include behavior management and hospitalization services which require prior authorization. This information has been utilized by the DMU to identify 7 providers as excepting for behavior management. Cases have been opened on those 7 providers and the other top 18 utilizers of behavior management have been sent an educational letter reiterating the program guidelines for authorization and documentation of behavior management.

  An additional exception was reviewed regarding hospitalization services. This finding will be discussed under the "Potential Overuse of Hospitalization Services" Section.

- Finding: The LSU Dental Medicaid Unit (DMU) does not have the ability to analyze the total population of dental claims to identify potential fraud. The DMU relies on exception reports produced by the DHH Program Integrity section. These reports are not an effective tool to identify potential misuse of Medicaid resources.

Summary: We concur with the findings. The system of profiling dental providers within the computerized Surveillance and Utilization Review Subsystem has been in place since the early 1980's. This system called the SURS II system which enables the agency to profile providers by a series of control file lines which can be adjusted quarterly to identify trends which the reviewers would like to measure. There are pro's and con's to using this system but it was the subsystem that was certified by HCFA for performing these functions in the 1980's when HCFA performed review functions.

In the latest MMIS contract awarded to Unisys, the contractor was required to purchase and install a new system of Surveillance and Utilization Review called PC SURS, a state of the art program for detecting abuse and aberrant providers in an easier and more responsive time frame.

Corrective Action: We concur with your recommendation that Dental providers should be subjected to the same SURS review as all other providers and will move to implement PC SURS in the dental program. The dental control file will be updated to improve exception profiling. We anticipate that this corrective action will be completed within 90 days.

Corrective Action To Date: The DMU is working with Program Integrity SURS Unit to utilize the PC SURS to the fullest extent. The DMU will make regular visits to Program Integrity SURS Unit to run needed reports.

- Finding: A review of the case files at the dental school revealed that two cases where the dental consultants were aware of improper billings to the Medicaid program; however, no action was taken to recoup the improper payments or follow up to ensure that the improper billing practices were stopped.

Summary: We concur in part with the findings. Once reviews are completed, the agency has options regarding sanctions. Page 8-9 of the Dental Manual details the level of sanctions that can be imposed by the reviewer. We do agree that the billing of services prior to the delivery is a violation of policy, we note in your findings that the provider was appropriately sanctioned but not recouped. The letter addressed to Dr. Daryl Westmoreland, provided as part of your review, document that the dental contractor issued the first level sanction outlined in the manual and the provider was warned of further consequences should the infraction occur

again. This appears to be an appropriate response to the identified problem. These sanctions don't always result or start with recouping funds as the first level of discipline. The circumstances of the violation and the impact on the service provided are taken into consideration when imposing such a sanction. The second example addressed to Mr. Keith LeJune should have generated an administrative sanction to the provider regarding the improper billing.

Corrective Action: LSU Dental consultants will impose an appropriate sanction, as listed on Page 8-9 of the Medicaid Dental Services Manual when a provider is in violation of policy.

The Bureau will select a sample of cases reviewed by Dental SURS to monitor the appropriateness of action taken by the contractor. Documentation of such monitoring will be provided to the contractor. We anticipate that this corrective action will be completed within 90 days.

Corrective Action To Date: The DMU has drafted a sanction letter to use when a provider is in violation of policy and will be implemented as soon as approved by DHH. The DMU has drafted a follow-up review letter to schedule a follow-up review of the sanctioned provider and will be implemented as soon as approved by DHH.

Pre-Authorization Procedures for Certain Services Not Followed

- Finding: Dental procedures authorized and paid without x-rays being submitted.

Summary: We concur in part with this audit finding. The Medicaid Dental Services Manual (Page 4-8) states that "In cases where the provider considers radiographs to be medically contraindicated, a narrative documentation will state the contraindication." Some providers may include this narrative documentation on only one copy of the two required claim forms submitted to the LSU Dental Medicaid Unit (DMU) for authorization. The copy that includes the narrative documentation is the copy that is retained by the DMU. These written comments may contain sufficient information to allow the authorizing process to proceed even if the copy included in the patient's record does not.

Corrective Action: The DMU will not authorize services requiring radiographs unless a narrative documentation stating the contraindication is received. If a request for prior authorization is received without proper documentation, the request will be returned to the provider requesting proper documentation.

A provider update or remittance advice (RA) message will be generated reminding dental providers that the medical contraindication for not supplying x-rays must be documented on the prior authorization request, in the "Remarks" section, when submitted to the DMU and also in the patient's record. The provider update or RA message will also require that two identical copies of the prior authorization request be submitted to the DMU and that the copy returned from the DMU must be retained in the patient's record. The provider update or remittance advice message will indicate that if the returned copy of the prior authorization request is not located in the patient's record or if written justification is not noted in the "Remarks" section of the request form then a provider sanction will occur. We anticipate that this *corrective action will be completed within 30 days.*

Steps Taken to Ensure Compliance: Prior authorization requests without radiographs (or no documentation why radiographs are not available) are returned by the DMU to the provider for that information. Additionally, beginning June 1, 2000, as claims are marked "received" at the DMU those that have x-rays attached are stamped "x-rays received."

The DMU requires two identical copies of the prior authorization request when x-rays are not being submitted due to a contraindication. If the DMU does not receive two prior authorization requests or if the prior authorization requests are not identical, they are returned to the provider for correction.

A remittance advice message was generated on May 23, 2000 and June 13, 2000 in order to remind providers of the above-mentioned policies and procedures.

- Finding: Hospital services had been authorized and paid without the required justification.

Summary: We concur in part with this audit finding. The Medicaid Dental Services Manual (Page 4-17) states that "hospitalization solely for the convenience of the patient or the dentist is not allowed. Hospitalization must be justified by the physical condition of the patient, the age of the patient, or the severity of the procedure performed." It further states that " . . . providers should submit documentation of the reason for the request for hospitalization, and they should forward the treatment plan to the dental consultants for review and approval." In administering this program, documentation is received by the DMU and is retained in their records as documentation as to what services were approved. Some providers may only provide hospitalization justification information on one of the two claim forms submitted for authorization. This is the copy retained by the DMU. These comments may contain sufficient information to allow the authorizing process to proceed even if the copy included in the patient's record does not. In some instances, in order to approve hospital services, the DMU's dental Medicaid consultants may have been able to use their professional judgement as to the age of the patient and/or the number of procedures required.

Corrective Action: The DMU will authorize hospitalization services only if the required justification information is provided with the prior authorization request. Should a prior authorization request for hospitalization services be received by the DMU without the proper justification documented, it will be returned to the provider requesting proper justification documentation.

A provider update or remittance advice message will be generated in order to remind providers that they must provide written justification in the "Remarks" section of the request form submitted to the DMU when requesting prior authorization for payment of hospital services. It will also require that two identical copies of the

prior authorization request be submitted to the DMU and that the copy returned from the DMU must be kept in the patient's record.

The provider update or remittance advice message will indicate that if the returned copy of the prior authorization request is not located in the patient's record or if written justification is not noted in the "Remarks" section of the request form then a provider sanction will occur. We anticipate that this corrective action will be completed within 30 days.

Steps Taken to Ensure Compliance: The DMU returns all hospitalization prior authorization requests which do not indicate the reason why hospitalization services were being requested. In addition to returning the information to the provider, the DMU requests that the provider supply this information and resubmit. Documentation is made on phone calls to providers related to a specific PA request.

The DMU requires two identical copies of the prior authorization request when hospital service are being requested. If the DMU does not receive two requests or if the prior authorization requests are not identical, they are returned to the provider for correction.

A remittance advice was generated on May 23, 2000 and June 13, 2000 in order to remind providers of the above-mentioned policies and procedures.

Matters for Additional Consideration

Potential Overuse of Hospitalization Services

- Certain dental providers are possibly billing the Medical Assistance Program for unnecessary hospital services.

Agency Response:

It is agreed that the Department of Health and Hospitals will take appropriate action to ensure that hospitalization services are utilized according to Medicaid policy and to review the top utilizers of hospitalization as indicated on the exception reports. Listed below are the Departments efforts toward this goal:

A remittance advice message was generated on May 23, 2000 and June 13, 2000 reiterating the conditions which must be met for hospitalization.

An exception report was run on PC SURS at the request of the DMU for hospitalized services. The 5 providers who excepted have had cases opened and the other twenty top utilizers have been mailed an educational letter concerning the requirements for reimbursement and documentation of hospital services.

A request to periodically include an exception area addressing the percent of hospital services will be made by the DMU. This information will be utilized by the DMU to review those providers that excepted.

Hospitalization Service, which is covered by Medicaid, is based on the rules and regulations of the Medicaid Dental Program. The professional judgement of the dentist is applied when using these criteria. The decision to subject any patient to the risks attendant to general anesthesia is not one to be taken lightly. General anesthesia and other regulated forms of analgesia/anesthesia may only be prescribed by licensed individuals and in the case of dentists are even further regulated by the State Board of Dental Examiners in that special licenses beyond the one required for dental practice are required by law and must be renewed on a regular basis. Additional specialized training is required, in fact not every pediatric dentist in the state can qualify for these licenses. This factor may help explain why some dentists utilize various forms of behavior control (behavior management, conscious sedation, IV sedation, nitrous oxide and general anesthesia in a hospital or outpatient surgery center) on varying bases.

The providers selected in this audit are pediatric specialists, whose patients consist of children, some of whom are referred to them by other general dental providers (and in some cases pediatric dentists), who cannot successfully manage these patients in the regular office setting. Each of these dentists is entitled under the Dental Practice Act of the State of Louisiana to practice in the manner he or she deems most appropriate for his or her patients. We do not dispute that there are differences in practice methodologies and parameters between many of the providers in the program and that some pediatric dentist may be better equipped or feel more confident to treat

these cases in a hospital setting than others. An additional consideration is that most general dentists do not have admitting and/or operating room privileges. Finally, not all surgery centers are willing to accept patients for dental surgery which may explain why dentists in certain areas do not hospitalize their patients.

Possibility for Conflict of Interest between the Dental Medicaid Unit and the LSU School of Dentistry.

Agency Response:

In an effort to avoid a conflict of interest, the following protocol is currently being followed for reviewing claims originating from the LSU School of Dentistry.

Dr. Robert Barsley and Dr. Robert Musselman, two of the four current dental consultants, are faculty members of LSU. Dr. Barsley does not currently treat patients in any clinic (school or otherwise) and does not have a Louisiana Medicaid provider number. Dr. Musselman is an enrolled provider and does treat Medicaid-eligible recipients in the Faculty Practice.

Dr. William Duvic and Dr. Frank Herbert, the remaining two dental consultants are not members of the faculty at the present time. Each is contracted to serve as a dental consultant to DHH - BHSF under the current contract with the LSUHSC. Neither of these dentists currently treat patients in either the school clinics or in any other practice setting. Dr. Duvic does maintain his Louisiana Medicaid Provider Number as a means of accessing certain informational services of DHH that require a valid Medicaid Provider Number for entry. Dr. Duvic has not claimed reimbursement on this provider number for a number of years. Dr. Herbert is not an enrolled provider.

Claims from the School of Dentistry clinics are segregated and reviewed by Drs. Duvic and Herbert. On rare occasions, Dr. Barsley may be required to review claims from the LSU Dental School in order to resolve questions raised by the other two consultants, or in cases where they are not available to complete a review in a timely fashion.

Dr. Musselman never reviews claims from the LSUSD clinics. As the former head of Pediatric Dentistry, he is a most valuable member of the consultant staff, reviewing those claims that require the additional expertise of a pediatric dentist.

At the time Dr. Musselman was engaged as a consultant, the School of Dentistry did not accept Medicaid as a form of payment. It has only been in the last few years that any clinic in the school accepted Medicaid.